Critical incident report from the IAKH-Fehlerregister

in cooperation with the DIVI and the CIRSmedical Anästhesiologie of BDA/DGAI and ÄZQ

Report via  **IAKH Fehlerregister**  **CIRSmedical AINS of BDA/DGAI and ÄZQ**

Topic/Title	**Transfusion to the wrong recipient with the same blood group**
Case -ID	**CM5311/2010**
Case report (approx. as entered)	**During a postoperative haemorrhage on ICU at a patient, that recently had been admitted from the OR together with the blood bags ordered for him. There are dedicated storage facilities for blood units in the OR and sometimes also in ICU. Since anaemia was moderate to considerable and blood pressure drop sincere, the ward physician in charge performed a bed side test of the blood group (A; B; 0), compared with the one of the attached cross match document and administered the red cells. The transfusion period was uneventful. Later, the packed red cells for a patient in the OR were missed and in parallel the originally prepared units for the Patient already on ICU were found and delivered to the ICU by the recovery nurse. The mix- up was detected but the administration process completed long ago. The name on the cross match documentation sheet had not been compared with the patients ID, only the blood group an the number. In Germany, the cross match result is either labelled to the blood unit directly or attached to the document as a separate sheet of paper. It gives also the blood group but mainly testifies the compatibility of the donors blood with the recipient , so name and birth dates of the expected recipient are given also. The patient did not have any clinical signs of transfusion reaction and the result of the cross match redo in the case was a fit.**
Problems (here: questions that arise the possibility of problems- there had been no possibility for follow up queeries)	• **The initial mix up was at leaving the OR. This is a busy moment since a lot of hands are on the patient, his/her documents, monitors, ventilator (if still intubated) cables and iv-lines. In addition, when the distance to the ICU is far or the ICU equipped with own storage capacity of red cells, then the blood in addition is to transport with or without special cooler bags to the ICU. It is to assume that someone in a hurry was grabbing the wrong blood units out of the fridge in the OR and gave it with the patient. ICU staff trusted the correctness of combinated delivery of a**

	patient accompanied by ("his") blood. • **The second error was the incomplete comparison of not only the bed side test with the blood group formula on the bag and the cross match sheet but the ID of the recipient with the subject the blood was tested for.** • **The risk was twofold.** **1- that a special antibody constellation even with compatible major blood formula harms the recipient** **2- the unavailability of the blood units dedicated to the second patient in the OR were not available any longer and transfusion delayed.**
Process Step concerned **	**3- transport, storage, 5-administration, ID check**
Circumstances	**Routine, OR/ICU-interface, ASA 3, experienced doctor**
Good elements ("as reported" or criticism of the CIRS Board	**SOP for the entourage of blood units with patients transferred out of the OR onto ICU seems to exist**
***Risk of reoccurrence/Likleyhood**	**4 of 5**
***Potential risk for patient damage**	**5 of 5**
Board recommendation (Suggestion of a change of process and/or structural quality by introduction /installation/reeducation of the following measures)	**Process quality:** • **Two person double check before administration of a blood unit / 4 eye procedure strongly is recommended** • **For better recognition of the intended recipients name and birth date- use bigger font or other colour on the document/label** • **Education of the staff involved in the processes at the OR gate- Highly alertness for the correct assignment of blood products out of the fridge is necessary** • **Educate staff according a SOP administration and ID check** **Struktural quality:** • **Blood storage facitlity/fridge should have clear sections for each OR table** • **Consider electronic control, match and documentation of administration process of blood units (i.e. bed side PDMS)** • **Consider cooled transport of blood units in special containers**

*Risk Grades:

Frequency, Risk of reoccurrence		Potential risk for patient damage	
1/5	**very rare** **max 1/100 000**	**1/5**	**very little acute injury/no permanent damage**
2/5	**rare** **max. 1/10 000**	**2/5**	**minor acute injury/slight permanent damage**
3/5	**medium** **max. 1/1000**	**3/5**	**considerable acute injury/** **minor permanent damage**
4/5	**frequent, min. 1/100**	**4/5**	**profound acute injury / considerable permanent damage**
5/5	**usual/common, min. 1/10**	**5/5**	**death/severe permanent damage**

****Allocation of errors/near misses in the process of administration of blood or coagulation products**

1. -blood sample withdrawal
2. -blood order
3. -laboratory
4. -handling or storage
5. -blood product release, transportation, or administration

15. -sample/product/patient identification